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TOKEN RELATIONSHIPS: A STUDY IN COUNTERFEIT INTERACTION

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Too often those of us who are working with people feel that our responsibility toward them and for them is discharged when we have made it possible for them to act as we think best. Occasionally, however, such an endeavor misfires with sufficient report to cause us to scrutinize our own assumptions.

One day last spring a middle-aged woman came in and, before she had removed her gloves, exclaimed:

> "I'm nothing but a tool! People just use me when they want something done and in between they never think of me any more than they would of a paring knife! They won't let me be *real.* I want to be a person, not just someone to do chores or hold offices."

All this was surprising, for Jane is a warm, attractive, outgoing, and friendly person always full of gay quips, amusing stories, and enthusiastic accounts of what she has been doing. While she lived alone and has no relatives, she worked in a store, was secretary of her club, treasurer of a church study group, and taught a Sunday School class. She seemed to get along well with her fellow workers; the customers liked her and asked for her. She went to concerts, usually with someone from the store, sometimes with another

friend or her landlady. Her room was pleasant; she had a good job, had recently been granted an increase in salary and her employer was open in his praise for her. Outwardly, there was nothing to account for such bitterness or for her feeling that she meant nothing.

As she went on talking about her resentment and feeling of being negated and dehumanized by her environment, it became clear that she was isolated in the midst of a crowd. She was rarely alone and always on the go, but no companion held over from one activity to another. All her contacts were fortuitous ones, shifting as rapidly as two rivulets of water on a windowpane. She always ate lunch with one of her co-workers but the choice depended upon who was in the cloakroom when she went for her wraps. It was usually she who had bought the tickets for the concert and suggested going, and after it was over she and the friend separated with promises to "call each other up some time."

When Jane's mother died a few years ago and she came to the city to live, she followed the advice usually given to people who live alone. She joined a church, became active in a number of organizations, developed a host of interests, made many social contacts.

All of her contacts, however, were *surface* contacts, carried on in the framework of token relationships on the level of polite social exchange. No group was organic, fixed, lasting. All were tenuous clusters of individuals who met momentarily for a common purpose and then dispersed, to meet with another cluster for another purpose and another goal. There was no one with whom she meshed, of whose life she was an integral part, whose role could not be well filled by another. If she lunched with a girl, it was with a co-worker, and they talked over the affairs of the store. As secretary of her club she often met with the president, but it was a secretary and a president making plans, not Jane and another human being making friends. She went to a concert, but she was paying back a social debt or "making a gesture" toward friendship. In other words, all her relationships were *status* relationships. All her behavior was *role* behavior. As a Sunday School teacher she fulfilled certain duties and was responded to in a certain way but was forgotten and forgot until the next week rolled around. She was a good clerk, a conscientious secretary, an accurate treasurer, a faithful teacher. But there was no one to whom she meant anything.

Fundamentally, just people aren't enough. Activities aren't enough. A busy social life can be a barren, isolated, bitter one. In order to avoid more than that degree of loneliness necessitated by the fact that we are each discreet individuals living essentially within our own depths and unable ever to communicate fully with another, there must be a few *key* relationships which persist and cut below the level of social exchange to become part of a living, growing, emotional life.

In order for contact to become a relationship there must be continuity of exchange, freedom of communication, repetition of meeting.

The capacity for friendship may be born in us, but the ability to be a friend must be learned. The rules may be transmitted by precept, but the act and the feeling must be gained by example and by experience. A child learns to love by being loved, and rejected children or those growing up in institutions often have a difficult time finding out how to get into close relationship with another.

A baby is loved by its mother and fondled and talked to in a certain tone of voice and looked at with a certain warm expression. It has specific needs and these are met by warmth and giving. All this makes the baby comfortable and it responds with smiles or nestling, stops its crying and makes cooing sounds. This response makes the mother happy and becomes more giving. Being filled with love, the growing child spills over and wants to love back. And without knowing that it has done so, it copies and develops a way of behaving which gives pleasure and awakens a cherishing, approaching response in another and a desire to give back. Without being consciously aware, it has learned that to smile, speak pleasantly, commend, give a gift, do something for someone makes that person come closer and act in such a way that pleasure and warmth are returned. It has learned how to love and to evoke love.

As it grows older it discovers that rewards can come from the exchange of experiences and the sharing of opinions. Usually it is fortunate enough to have continuity in its relationships guaranteed, and, when it meets a new person or gets into a new environment, knows how to go about calling forth a warm response and making a new friend.

But occasionally there are people who have been deprived of this opportunity to copy ways of behaving in order to get closer to people or who have been hurt so often by death, disillusionment, or removal that they have forgotten how to open up and invite love, or who have become fearful of further hurt and have retreated behind a safe wall. Such a person must be taught anew how to make a meaningful relationship, and, like the baby, he must be taught by experiencing, learn by doing. Given one warm relationship, he can spread out and form others, but the pattern usually must come from someone else; left to himself, he can make the gesture, act as if, but never experience, or know the rewards. And one of the basic requirements for forming that pattern is that the other person, the model, be receptive, responsive, and sharing.

The primary point in Jane's story is that one can go through the *motions* of friendliness without the *emotions*, can make the gestures which go with belongingness and remain an alien.

But Jane's experience also shows something else. As it turned out, the chief reason for her feeling that she did not exist except as she fulfilled a function, that she had no reality, that life was barren, was that she had no one to whom to tell the happy things. She could not share a tribute, savour a compliment, rejoice over a job well done. She had been receiving a number of rewards, but because there was no one to share them

there were no rewards. She became empty and felt that she had no value, no real existence; and the vehicles (which should have increased her sense of status) — the promotion, the commendation, the plan which worked out successfully and brought thanks, had no meaning. As she said,

> "If you're unhappy or in trouble you can always find somebody to listen to you for five minutes. They may not like it, but if you are in a real jam they will try to help you out. It makes them feel important. But you can't tell them the nice things. They think you're queer or conceited."

This seemed rather a drastic statement, but it turned out Jane was right. She tried telling "the happy things," as she put it, and met rejection.

Thinking there might be something in her personality or manner of reporting which colored the response she received, three others — a psychiatrist, a psychologist, and a research worker — carried out an informal experiment. All found that on the whole people are intolerant of another's triumphs. Usually the reaction took one of two forms. The listener said, "How nice" and immediately reported a greater success of his own; or he made a perfunctory response and went on — most frequently in the same conversation, occasionally not until the next meeting — to a verbal attack: a criticism, a rebuke, an accusation, or even to what looked like a deliberate attempt to pick a quarrel. It was as though the successful one could not be allowed "to get away with it."

It was, of course, possible to find those who could accept another's achievement. But without exception such people had one attribute in common: they were close enough that the success was *their* success, the increased status *their* increased status, the recognition *their* recognition. They were a father, a mother, a brother or sister (if competition for the same reward or in the same field did not come into play), a husband or wife, an employer who gained stature because he could command such ability, a teacher who had nurtured and trained such talent, an older, nurturing friend or one of the opposite sex. In other words, the relationship had to be close enough that the listener could share in the success and appropriate the glory or be himself rewarded by the enhanced value of the other.

The meat, then, of Jane's whole story — and the reason for relating it — can be summed up very briefly. It is not enough to tell the isolated, lonely person to get out and do things. He must be helped to form a relationship which has continuity, repetitiveness, frequency of contact, and meaningfulness. And we all—particularly the solitary — must be able to share the *goods* as well as the *bads*. And both needs, to share and to belong, can be met, in part at least, by one act: happy, receptive listening which is responsive to the joys as well as sympathetic to the sorrows.

Opportunities for such listening — which accepts and shares, responds and points the way — are not always easily come by. The average person

has learned his lesson, particularly the average lonely person. He knows that he can talk about a show, a concert, a book (if he chooses the right listener), an episode on the subway, an encounter with an unreasonable person, a momentary irritation with the boss (if he is speaking to a co-worker), the weather, the rules of a game, the headlines in the paper. Without conscious plan, he learns to pick his topic to fit the experience or potential experience of his listener. But he is afraid to cut deeper, especially to report a success or share a joy, unless he can be sure the other person "really cares." But one of the problems of modern living, especially of urban living, is that there are few people who care.

The picture presented so far has been rather grim; unsatisfied human needs often are. The conviction behind its telling is not. All of us have known sensitive, perceptive, loving human beings who have learned to see behind the words and respond to the need being expressed. Many more, once the need has been pointed out to them, are quick to serve. Here then is a new chance for service, the service of joy.

SPIRITUAL CRISES IN ILLNESS

REV. RUSSELL L. DICKS, *Chaplain*
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TO UNDERSTAND the chaplain's contribution to the care of the patient one must understand the nature of illness itself. My own understanding of the psychology of the sickroom and the care of the patient is drawn from an experience of having been a patient in ten different hospitals; of having been operated upon seven times; of having worked in four hospitals; of having been associated with some of the nation's greatest, as well as poorest, doctors; of having spent literally hundreds of hours listening to physicians talk, both formally and informally, about illness, medicine and the care of the patient; of having written numerous pamphlets, articles and books; during which time through brooding, sweat and discipline, I searched out and examined every insight, idea and conviction that I had ever come across which would enable me to carry on a more effective ministry to the sick. The sum total of my findings concerning the nature of illness is that illness is basically, from the standpoint of the patient, (and aside from the patient it has no meaning) a spiritual problem and health is a spiritual condition.

If it is true, as Harvard Medical School's late physiologist, Dr. Walter B. Cannon, has said, that "the human body is so constructed as to go on functioning almost indefinitely without becoming ill," we have to ask the question, why do we become sick? Medical science does not answer the question; religio-philosophy, which is not bound by the limits of science, offers a suggestion. It says we become sick, both physically and mentally, because of inadequate ways in which we learn to handle our emotions of fear, guilt feelings and loneliness.

Spiritual Implications of Illness

It is commonplace for the general practitioner to tell us that between 50 and 75 per cent of his patients, depending upon the kindliness and interest of the doctor, are persons without organic disease. The scientifically trained doctor, under the influence of modern psychiatry, now recognizes that a person who thinks he is sick is *as* sick, if not more so, as the person who has demonstrable organic disease. Dr. Flanders

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Taken from an address to the American Protestant Hospital Association Convention, St. Louis, September, 1947.

Dunbar found that some 76 per cent of a large series of patients which she studied at Presbyterian Hospital, New York, suffering from fractures gave evidence of having a psychogenic cause underlying the accident which led to their injury. Dr. Dunbar has said, "It is not a question of whether an illness is psycho or somatic but rather a question of how much of each."

It is obvious that the illness which is psychogenic or even partially psychogenic has tremendous implications for religion, for religion deals with the interpretation of life and attempts to put meaning into living. To fail to help people who have problems of this nature is to fail as completely as if we failed to treat an organic disease. For instance, I have never been able to understand the common practice of treating the organic symptoms of a person who has tried to commit suicide, through pumping out his stomach, giving him intravenous fluids and fulfilling all the ritual of good physical treatment, and then sending the patient home without anyone talking to him about what led him to the act. Since when has the problem of suicide been a physical problem, aside from how it is to be done?

Accepting the Diagnosis

Let us look at five great crises of illness and see to what extent they are spiritual in nature. These are physical insofar as the presenting problem is concerned. The first is the acceptance of one's diagnosis. The emotion of apprehension, or fear, is so great in connection with this crisis that many persons delay seeking a doctor's help so long that it is impossible for them to be helped when they do go to a physician and in other instances so severe that the doctor withholds the diagnosis from the patient once it is complete, judging the patient as being unable emotionally to accept the information which the doctor has learned about him. This is a religious problem, for all religion teaches that we should be able to accept whatever experiences come to us and turn them into triumphant living.

Facing an Operation

The number two crisis in illness is the surgical operation. We are told by doctors that surgery is a matter of mechanics; the surgeon speaks of himself as a mechanic, the orthopedic surgeon, as a carpenter, the urologist, as a plumber. While surgery may be a mechanical process from the standpoint of the surgeon and his assistants, it is a spiritual experience from the standpoint of the patient. For him it is an act of faith. Faith in the surgeon, that he has the knowledge and skill to do the job before him; faith in the anesthetist that she will be able to keep him both free from pain and alive; faith in the nature of the universe, or God, to work through the healing forces of nature for his recovery. At the Massachusetts General Hospital in Boston we asked a large series of

patients facing operation the routine question, calmly and casually, "How do you feel about it?" Approximately 90 per cent talked about religion, saying in words to this effect, "My confidence is in my surgeon and God." The surgeon got in ahead of God but then subconsciously they probably realized they had better be more concerned about the surgeon than God for they could be certain that God would not mess up the surgeon's work while the surgeon might mess up God's work.

3 Adjusting to a Handicap

The third great crisis in illness is the person who faces life with a physical handicap following treatment: the person who has a heart attack and must live on a restricted physical activity regime the rest of his life, the person who has diabetes and must take insulin, the person with an ileostomy or colostomy, the person with an ulcer who must live on a strict diet, the person who has had infantile paralysis and is left with muscle weakness, the person who is blind, who loses an arm, leg or the use of a joint, and many others. Almost all physical handicaps, aside from war casualties and great physical calamities like tornadoes, fires and such, where being wounded or injured is preferred to death, almost all other handicaps are interpreted as a special visitation from God. Even the sophisticated believe they have been singled out in some special way by the universe. Mastery of and compensation for a physical handicap is a triumph in living by the spirit. We see many fail and fall short of an adequate mastery of physical limitation. Sometimes the failure is the fault of the patient's parents, friends or employers. Above everything else one must have hope, courage and perspective. These are attributes of religion, not easily come by but more than adequate when patiently and wisely sought.

4 Loneliness and Boredom

The fourth crisis seen in the sickroom is that which may accompany a long convalescence when loneliness sets in, when the spirit dries up and the mind turns in upon itself. The radio, with its varied palaver, both helps and destroys the soul during such a time, while I suppose when television becomes commonplace, so many people will become sick, especially during the world series, that there will be no one to care for them. Loneliness and boredom are emotional forces which may lead either to a destruction of the soul or may lead it into experiences of socialized and creative living. All religions agree that friendliness and trust are the very essence of religion.

5 Meeting Death

The fifth and final crisis of illness is death. This so obviously is a spiritual problem for the patient that I need spend little time discussing

it. Only religion has anything to say to the dying person; only religion looks upon this experience as a beginning and not an end, a possible triumph and not an absolute failure. If the chaplain did nothing more than minister to the dying he would more than justify the cost of maintaining his work, judged from any standpoint you wish, particularly from that of the so-called hard-boiled scientifically trained physician, who is apt to fumble his care of the dying so badly. He, above all, welcomes the chaplain's ministry to the dying and praises him eloquently when he secures permission for an autopsy by simply pointing out to a family that that which they loved is no longer in the body and that what happens to it, so long as it is treated with respect, is of little importance.

Pastoral Therapy

What about the chaplain's contribution to the care of the patient, and how does he serve in the great crises of illness? When he knows something of the psychology of illness as described above, plus the great emotions of fear, guilt feelings and loneliness, which may be found in persons who have no organic problem, as well as in those who have, he may be of tremendous help. But the minister, priest or rabbi will not know how to carry on his ministry in the sickroom without special preparation for his task. It is not enough to be, as a Bishop described a minister he had appointed as hospital chaplain, with the approval but not at the request of the administrator, "He is a lovely person around the sick." Does "loveliness" of spirit, whatever in the world that is, insure one of some judgment, some discipline, some skill? One might as well seek a surgeon who is kind and pleasant but who has never studied anatomy, nor served as apprentice in the operating room with an experienced surgeon. The art of surgery is in knowing what to cut and what not to cut. The art of ministering to the sick is in knowing what to ask and what not to ask; what to say and what not to say; when to pray and when not to pray; when to leave and when to stay. The art of ministering to the sick is the ability to follow your leads, for if given the chance the patient will carry you to his need.

Summary

It is a safe estimate that some 50 to 75 per cent of the doctor's and the chaplain's work overlaps. That is to say, a patient would be equally helped by either a doctor or minister, granted good nursing care; for both the doctor and the minister are dealing with spiritual problems; both serve the same healing forces, both follow the same first principle of *do no harm*, for both know that if they can avoid doing harm, most of their patients will get well. If they will cooperate, God, working through nature, will use them. It is not that the clergyman has moved into the treatment of the body, but the physician has moved into the treatment of the soul, not just in psychiatry but in the whole of the practice of medi-

cine. It is a demonstrated and well-recognized fact that the physician welcomes us as allies when we work along sound lines; when we cooperate with him and do not work independent of him; when we are interested in the patient as an individual, and not in the number of people we can get to agree to a prescribed formula which we interpret as meaning salvation regardless of the patient's mental attitude. The doctor welcomes us when we fit into the hospital routine and do not act as little tin gods on a string. At one hospital where I worked I was told that if I could just stay out of trouble for a year, it would be a major achievement because my predecessor was so thoroughly disliked.

THEOLOGICAL AND PSYCHIATRIC INTERPRETATIONS OF HUMAN NATURE

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MANY people who have long since found a peaceful settlement for the traditional battle between religion and the physical sciences are now asking how the Christian doctrine of man can be reconciled with the secular sciences of man. This essay will be confined to one important aspect of the general problem, namely, the apparent conflict between theological teachings about sin and psycho-therapeutic teachings about mental health.

The terms "neurosis" and "sin" often refer to the same set of facts, and the difference between the two is at least partly one of context. "Neuroses" arise as a result of biological, psychological and cultural maladjustments. "Sin" signifies, primarily, that alienation from God which results from the abuse of human freedom. Theoretically it should be possible for the theologian to incorporate the psychiatric account of neurosis within his conception of sin, and it should be possible for the psychiatrist to regard theological questions as outside the scope of his task. But this division of labor breaks down in practice. The psychiatrist must enter into the realm of theology at least to the extent of asking whether religious beliefs (in any particular case, or perhaps in every case) are illusory; and the theologian can hardly incorporate the psychiatric way of dealing with neuroses into his religious way of dealing with sin if the two are radically opposed to each other. Although a properly trained Christian minister can use to advantage many psychiatric teachings without accepting those which conflict with his religious beliefs, and a psychiatrist can "use" the religious faith of his patients without personally accepting its content, these helpful modes of provisional co-operation should not be allowed to prevent further inquiry into underlying disagreements.

The Doctrine of Original Sin

Our first task is to examine the most persuasive contemporary re-interpretations of the idea of original sin. Although they of course have a Biblical basis, they get rid of many of the absurdities that are to be found in older statements of the doctrine. For example, the notion

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that the consequences of Adam's Fall are transmitted seminally to the entire race, is completely rejected. The story in Genesis is accepted not as a literal account of how sin got started in 4004 B.C., but as a symbolically profound account of the predicament in which every man finds himself. Heretofore Christian theology has oscillated between a bad form of determinism, which regards man as enslaved by factors unrelated to his personal responsibility, and a bad form of indeterminism which overlooks the extent to which personal responsibility is circumscribed by "fateful" factors. Contemporary interpreters of the doctrine have sought to do justice to both the racial and the individual aspects of the problem. They take account of (1) the manner in which malignant social patterns tend to be perpetuated and to influence every individual adversely from birth, and (2) the manner in which evil motives arise within each person as the result of self-centeredness. Moreover, they regard accounts of social and personal maladjustment as inadequate until these symptoms have been traced back to the fundamental cause of human misery, which is spiritual alienation from God.

Advocates of this Christian doctrine of sin claim that it does justice to certain facts concerning "the condition of man" that alternative secular theories minimize or overlook. One example must suffice to illustrate the point. Much recent American thought has explained sin away by attributing it to a temporary discrepancy between the progress of the physical sciences and the progress of the human sciences. It has assumed that once we become as intelligent in our control of economic, political and psychological events as we are in our control of nature, then the worst forms of evil will be eliminated. Recent history has done much to spread the suspicion that this assumption is a utopian dream, inasmuch as civilization has been brought to the brink of complete destruction not by a lack of information and techniques, but by fundamental defects in human motivation. What is needed is not so much an extension of knowledge as a radical transformation of the heart. Therefore the doctrine of original sin has the merit of locating the trouble at its source. There are roots of egotism, will-to-power and mistrust in human nature, collectively and individually; and from these roots sprout the evil blossoms of war, racial prejudice and class hatred, as well as such personal maladjustments as overweening ambition, cruelty, anxiety and isolation.

This same re-interpretation has had a salutary effect upon thought within the church. It has been a corrective against liberal theology insofar as the latter has reflected the undue optimism of its secular environment. It has also tended to shift the center of attention from "sins" as specific acts, to that underlying disorientation of the whole personality which is the real cause of the trouble. Far too often the list of "sins" on which conservative branches of the church are apt to expend most of their energy reflects the somewhat narrow standards of personal morality that happen to prevail in a given community; and a spurious sense of self-righteousness is built up through condemning

isolated acts, while the searching and revolutionary bearing of the Gospel upon the most serious social and psychological problems of our generation goes almost unheeded.

Perhaps employment of the phrase "original sin" has been a strategic blunder, since it arouses so much irrelevant resistance by its association with outworn notions; but we need some kind of strong language in order to describe the appalling misery and cruelty of the Twentieth Century. Whatever words we use, we must have a view of human nature that is adequate to account for the humiliating facts. It is fruitless to insist upon the "essential goodness" of a race that has produced the events of the last thirty years — not to mention the rest of human history.

In the face of the disastrous moral failures of our age, most men are tempted to shift the blame onto others. For example, at every social sore-point of American life — anti-Semitism, the Negro problem, labor unions, relations with Russia — one finds most people busily justifying their own attitudes and behavior. We tend to live by the formula: "What I do is all right; what my friends do is understandable; what 'outsiders' do is intolerable." Under such circumstances a doctrine of sin which makes a man aware of his own prejudices and rationalizations is sound, no matter how disagreeable it may be.

These are a few of the reasons why theologians feel that we need both a deepening of "the tragic sense of life" and a thorough arousal of conscience. They contend that a contrite recognition of the ultimate cause of selfishness, hatred, pride and mistrust is indispensable if there is to be any hope of finding a sufficient remedy.

Preliminary Psychiatric Criticism of the Doctrine

Why do the teachings of psychiatry seem to be incompatible with this renewed stress upon the doctrine of original sin? Psychiatric evidence indicates that condemnation directed against oneself and others is both futile and harmful. It is an obstacle, instead of a contribution, to an improvement of character. Therefore one of the things that psychotherapy is designed to provide is a human relationship where the "patient" will not be condemned; within such a relationship he can reduce the intensity of his self-rejection and of his hostility toward others. As he learns to accept himself and others, the way is opened for organizing personal relationships on a healthier and more satisfying basis. In order to fulfil this function, psycho-therapy must undo the emotional harm caused by prevailing cultural patterns. The harm usually begins in infancy when a child is accepted or rejected in accordance with whether he conforms to parental and other authoritarian demands. He learns to pass judgment on himself in their terms. Insofar as the parents and others who influence him are neurotic, they "use" the child for their own emotional purposes — a need to dominate, or to vindicate their own moral and social attitudes, or to compensate for unsatisfactory marital

relations, etc. Thus neuroses are transmitted from one generation to the next mainly by means of praise and blame; and in order to make a clean break with them it is necessary for the therapist to make a clean break with the attitudes that have caused them.

From a psychiatric viewpoint, therefore, even a carefully revised doctrine of sin tends to reflect and perpetuate neurotic patterns. It judges human life on the basis of authoritarian (divine) demands; it finds men incapable of fulfilling these demands; it then condemns them for their failure. The result is a deepening of psychological conflict instead of a curing of it. Psychiatry assumes that ideals should be flexibly adapted to the human situation instead of authoritarian; it also assumes that they should be appropriate to the capacities of the individual at any given stage of his development, and that anyone who clings to aims which are intrinsically beyond his reach is courting mental illness. Therefore it conflicts with Christianity insofar as the latter judges all men, irrespective of individual and group differences, by a standard which is admittedly beyond human attainment.

Anyone who believes that there must be a universal and humanly irremediable discrepancy between ideal aims and actual performance carries a heavy burden of despair and guilt. One of the most familiar consequences in the history of religion is a combination of self-righteousness and self-hatred. These are not mutually exclusive, for in the latter case the individual preserves one segment of himself as extremely high-minded, ethically sensitive, contrite and "acceptable to God" by condemning the rest of himself. Hence having a strong sense of sin may not be as humble as it looks. As a matter of fact, the literature of psychotherapy shows that egotistical pride and self-rejection, instead of characterizing opposite sorts of persons, are found together in functional counterbalance within the same person. (Frequently one factor is predominant in consciousness while its counterpart is predominantly unconscious.) If this is true, then the most effective way to reduce the selfishness of the human race is not to intensify guilt-feelings; on the contrary, it is to find a form of emotional security (self-acceptance) which makes both self-aggrandizement and self-repudiation unnecessary. These psychiatric observations can be documented clinically. Patients who scold themselves for a certain "habit" tend to go right on repeating that "habit." Only when guilt-feelings have been reduced can the patient gain insight into how this undesirable form of behavior originated and how it has performed important functions in his total life-strategy. Such insight is usually indispensable for any permanent improvement.

Accordingly, when a psychiatrist encounters severe feelings of guilt, he assumes that the patient's ideals are not entirely appropriate to his special abilities and limitations, and that they are being followed compulsively instead of whole-heartedly; hence he works for a revision of ideals as well as impulses so that both can be integrated within the person. Because he knows that when a man's inward condition is unsound

his ideal aims are bound to reflect that fact, the psychiatrist cannot accept any theological position which maintains that despite their universal sinfulness men can and should acknowledge an absolute standard which calls for no criticism or revision.

Now that both sides of the debate have been presented, at least in a sketchy form, let us select a few of the major issues for further investigation.

Concerning the Deepening of Conflict

It is misleading to assume that theologians merely want to deepen the sense of guilt while psychiatrists merely want to ignore it. Actually, the two positions can be brought much more closely together. The theologian stresses sin because he believes that recognition of its disastrous consequences may give rise to repentance and that repentance is the first step toward a transformation of character. His guiding motive is, or ought to be, constructive instead of sadistic. Psychiatrists who reject belief in God regard the doctrine of sin as harmful because it leaves men in a hopeless predicament; but what they reject is the very factor which means, from a Christian standpoint, that the predicament is not hopeless. Hence the theologian has a right to contend that so long as the doctrine is not sadistically abused, it is indispensable to his task of describing and interpreting those feelings of guilt, anxiety and estrangement that are undeniably operative in the human race. When so regarded, it includes human evils which a person does not directly will at all, but in which he finds himself caught; as such it is similar to concepts which the psychiatrist regards as illuminating and unobjectionable.

Furthermore, a widening of awareness of bondage to neurotic patterns is usually unavoidable in the initial stages of psycho-therapy itself, and this increased insight temporarily intensifies conflict. Therefore the analogy between religious conversion and psycho-therapy may be fairly close, so long as the motive for allowing awareness of problems to arise is the ultimate relief and transformation of the troubled person.

It must be admitted, however, that this analogy is often concealed because preaching techniques differ radically from good counselling techniques. In the nature of the case, the preacher cannot control what effect his words will have upon each hearer. What he says may be salutary if the listener is strong enough to use a pricking of his conscience as a stimulus to the practical amendment of his life. But the same words may be futile or harmful in their effect upon others. A counselor, on the other hand, can adjust his responses to the peculiarities of each patient's personality. On the basis of diagnostic information and thorough familiarity with the "case," he can learn when to exert pressure and when to relax it. The patient has a chance to reply, as he never has in church. There is no suggestion that the counselor is occupying a vantage point of moral superiority, as there too often is with preachers. The

patient's readiness to absorb and to make constructive use of new insights determines the rate and the depth at which his patterns of guilt and anxiety are explored.

These observations suggest that a theoretical reconciliation between theology and psychiatry, if it can be achieved at all, will issue from a practical fusion of religious belief and psycho-therapeutic techniques in the work of pastoral counselling. At present instances of this fusion are so rare that one can do no more than call attention to such analogies as may provide a common ground for further investigation.

Concerning Dependence and Self-Sufficiency

The theologian has a remedy for sin and the psychiatrist has a remedy for neurosis, but the remedies seem to be utterly different, if not incompatible. On the one hand, salvation comes from outside the self as a gift of God's forgiving grace. (The "faith" by which man receives this gift is a trustful response of the whole personality in a restoration of fellowship, not intellectual acceptance of something absurd.) On the other hand, integration comes about through an internal development which enables the individual to become more self-sufficient. Let us examine these two alternatives.

When the fetters of the narrowly organized ego are broken through and the emancipating power floods in from "beyond the self," the theologian speaks of the operation of grace. Christianity associates this experience primarily with Christ, through whom God has done for man something that man, in his bondage to sin, cannot do for himself. There are of course various interpretations of this event in Christian theology. For our purposes the most noteworthy feature is that the releasing effects of divine forgiveness stand in sharp contrast with legalistic moral effort.

The psychiatric approach concentrates on the fact that most neurotic people need to develop a larger capacity for taking responsibility, instead of blaming their failures on others or expecting life to conform to their personal whims. It assumes that a large proportion of those human beings who are maladjusted possess undeveloped mental and physical resources which, when released, can go far toward solving their problems.

The antinomy between dependence on God and growth of human self-sufficiency is seemingly complete. Yet it can be partially resolved. On the theological side it is necessary to emphasize that belief in God is being abused when it is made into a substitute for fulfilling natural and human conditions that are within man's scope. On the psychiatric side it is necessary to recognize that an increasing capacity for responsibility is quite compatible with continued dependence upon forces beyond one's control. Then the way is clear for theology and psychiatry to agree that significant personal growth involves an interaction between factors within the ego and factors beyond it; indeed, the most "healing" insights often come more despite one's will than by means of it. Both can

also agree that a wise kind of love fosters independence instead of enslavement, and that the lack of it is a major cause of emotional maladjustment.

In other respects, however, the antinomy may remain irresolvable. Christianity ultimately attributes the creative and redemptive forces of life to God, whether they arise from within or from beyond the ego; and it assumes that human beatitude involves right relationships with God, as well as good social and personal adjustments. The psychiatrist may of course reject such beliefs, although he can hardly avoid having some sort of confidence in "healing powers" outside consciousness and voluntary effort, however he may interpret them.

Concerning Absolute and Relative Criteria

The theologian defines both sin and salvation in terms of an absolute criterion, while the psychiatrist assumes that criteria should be relative to the individual and cultural situation.

The psychiatrist's case against Christianity is likely to run somewhat as follows: Most men today look mainly or wholly to secular means for such personal or social betterment as they are likely to achieve. They are up against pressing, concrete problems where they need the guidance of criteria that are directly relevant to the situations they confront. The Christian goal for humanity seems irrelevant because it transcends historical conditions. It fails to give an adequate outlet for those natural and potentially constructive energies without which a man can hardly maintain existence in this competitive and often ruthless world. It places such severe restrictions upon self-assertiveness, sexual desire and the expression of resentment that it is plainly unsuited to meet the actualities of life.

A Christian theologian might well reply that his religion has been ethically dynamic precisely insofar as it has retained allegiance to a criterion which transcends historical relativities while remaining relevant to them. Only so has it been able to resist the pervasive human tendency to convert individual or cultural preferences, illegitimately, into universal principles. The psychiatrist's stress upon "feasibility," while acceptable so far as it goes, does not meet the case; for "feasibility" includes all actual and possible goods and evils, and therefore fails to provide a decisive basis for discrimination. The most important problems of life arise in connection with competing interests and goals all of which may be feasible. Psychiatry must itself presuppose an ideal of the good for man which is neither myopic nor provincial, if it is to work significantly for the improvement of individual patients and their surrounding culture.

The question remains as to whether the ultimate criterion which lies at the basis of one's value system should be anthropocentric or theocentric. Christianity, in adopting the latter alternative, assumes that men reach beatitude only insofar as their lives conform to principles of love and justice which are valid, whether they acknowledge them or not. So

far as Protestantism is concerned, the way is open to admit that these principles, which are grounded in God, will be understood and fulfilled imperfectly so long as men remain fallible and sinful. Attempts to evade this admission by means of an infallible Pope or an infallible Scripture lead to static dogmatism. Consequently the transcendent-yet-relevant criterion of Christianity may be regarded as its most valuable asset in carrying on the never ending task of revising and criticizing proximate goals, and in safeguarding against the perennial temptation to deify the prejudices and predilections of a particular individual, culture or church.

From the theologian's standpoint, an anthropocentric ethic is always subject to the peril of rationalizing itself into accepting the prevailing rules of the game — political, social and ethical — on the ground that one must not expect too much of human nature. Admittedly those prophets and reformers who have steadfastly resisted the evils of their day on the basis of their belief in God have been in a sense maladjusted, and their conflict with "the world" has often involved suffering as the inevitable accompaniment of their loyalty and love. But their maladjustment has made them ethical and spiritual pioneers, as contrasted with those well-integrated contemporaries who were not subject to such severe pangs of conscience.

Finally the theologian may contend that the psychiatrist, with his intimate knowledge of the explosive forces which lie below the surface of human consciousness, ought to be among the first to recognize that an anthropocentric ethic plays directly into the hands of contemporary totalitarianism and nihilism; for the basic assumption underlying these phenomena is that since all value-systems are human constructs, they should be organized in terms of desire and expediency.

Summary

The issues thus raised have far-reaching implications which cannot be pursued in this essay. Our discussion has indicated, however, certain respects in which theology and psychiatry can seek to learn from each other. Theology, in its concern to avoid compromising its absolute standard, is always in danger of minimizing secular, temporal, humanistic values and the role that man can play in achieving and maintaining them; for the same reason it may cause moral confusion by blaming men for things that they literally cannot help, or, conversely, for things that they have a right to do. Psychiatry, on the other hand, having started as an "a-moral" scientific enterprise, can no longer afford to remain such. Their task of releasing men from the injurious effects of moral conflict imposes upon psychiatrists a responsibility for developing a more unequivocal philosophy of the ends of life and culture than they have yet produced. At least they should collaborate, as many are eager to do, in the attempt to formulate such a philosophy. One indispensable qualification for this collaboration, on their part, is a sympathetic understanding of religious needs and resources.

EMERGENCY BAPTISM, WITH SPECIAL REFERENCE TO INFANTS

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WHEN a Baptist clergyman gives instruction for infant baptism, there must be some solid justification for the heresy. As a chaplain in a large teaching hospital, it is my privilege to share in the training program for nurses. Among my assignments is a class for student nurses on the pediatric service, dealing with the occasion and method for emergency baptism of children. Because many parish ministers are now serving as part-time or volunteer hospital chaplains and because many others may be called upon sometime in their ministry to carry out this religious ceremony or sacrament, I want to share here the criteria and data which has been gathered during the past year.

It is a truism that religious barriers rarely exist in time of crises. Nevertheless we arbitrarily define an emergency baptism as being an occasion when we proceed with the rite because the appropriate clergyman cannot be obtained. Even though the hospital chaplain should take care not to usurp the role of the parish minister, he need not permit his own religious timidity to cause him to avoid opportunities for service. We find that the trinitarian form of baptism is almost universally acceptable to Protestant, Orthodox, and Roman Catholic churches. The formula is: "I baptize thee in the name of the Father, and of the Son and of the Holy Ghost."

Generally speaking the Protestant churches with the congregational form of government do not practice infant baptism or at most consider it optional. For example, this would mean for the hospital chaplain that a child of parents who are Baptists, Disciples of Christ, or Friends (i.e. Quakers) should be baptized only at the request of the parents or with their permission. Most parents who are Congregationalists, Universalists, or Unitarians would be pleased to have their baby baptized but would not be particularly upset if no one thought to do it.

People who are members of churches with the presbyterian form of government tend to be a little more concerned about the ceremony of baptism. The attitude in the various Presbyterian, Evangelical and Reformed, and Brethren churches range all the way from considering baptism of infants a minor parental obligation to viewing it as a highly efficacious sacrament.

The clergy and laity of the churches with the episcopal form of government, with the exception of some branches of the Methodist Church,

think of infant baptism as essential. The chaplain can be certain that mothers and fathers who are communicants of the Protestant Episcopal Church, any of the Eastern Orthodox, Old Catholic, Lutheran, or Roman Catholic Churches will be extremely grateful if their seriously ill child is properly baptized.

Once again I would like to emphasize that the chaplain should strive to get a priest or minister of the same communion as the parents of the sick or dying child. If there is no time or if for other reasons he cannot succeed in obtaining the desired clergyman, he may then proceed with the baptismal service. If the chaplain uses the trinitarian formula and is sincere in performing the ritual, the baptism is acceptable as valid by all Christian churches including the Roman Catholic. As a matter of fact, any lay person, persons of another faith or of no faith, may administer the rite with equal validity if they repeat the formula correctly and intend to serve honestly. At the time of baptism the child need not be moved nor does he need to be conscious. A small amount of water should be poured on the patient's head or other part of the body *at the same time* the words of administration are being said. There should be sufficient water for it to move across the skin. Prayer, reading of scripture, or any extemporaneous or formal liturgy is not required but is highly appropriate if circumstances permit. The bare essentials required to make the baptism valid are (a) use of the correct formula, (b) sincerity of purpose, and (c) movement of water across the skin.

When the chaplain performs an emergency baptism, he will foster good will and understanding if he makes a habit of preparing four copies of the report of the ceremony. He should keep the original, give one copy to the parents, a copy to the institution in which he is serving, and send the final copy to the local parish clergyman who would normally have officiated if he had been available at the time of the emergency. A suggested form for this report is as follows:

To whom it may concern:
This is to certify that on (date) at (place) I baptized (full name) in the name of the Father and of the Son and of the Holy Ghost.
Signed.....

The chaplain should not only sign his name but also indicate his official position. If the parents have not chosen a name for the child, then the sex and family name should be inserted in the record — i.e., "Baby boy Jones." In such cases it is imperative that the names of both parents be also included in the record. If possible other data, such as the child's place and date of birth, name and address of the parents, and the names of any hospital personnel who were present at the service, should be included in the report.

While this spiritual ministration is not required professionally of the chaplain, there are times when, if he ignores the religious feelings and convictions of the parents of his small patients, he will fall short of fulfilling his high calling in Christ Jesus.

THE RELEVANCE OF RELIGION TO THE SICK

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Most scientific papers follow an established order such as introduction, methodology, experimental or clinical evidence, and conclusions. But as this is not strictly a scientific paper, I am going to reverse this procedure to the extent that I should like to state a "conclusion" as a sort of premise and then point out some specific implications of this position, citing some clinical material as evidence.

The Priority of the Soul

If we study the Gospels in a cursory manner, we are immediately confronted with a thought-provoking fact: — Jesus was not primarily concerned with curing bodily illness, despite the fact that he did perform healing miracles during his brief ministry. He healed people because of compassion or because of the person's faith. To be sure his loving and compassionate nature hated pain and suffering. Behind all this, however, were the primary purposes of his ministry: to convert people to his way of life and to bring out the faith that was in them — the same faith that sometimes enabled them to be relieved of their sicknesses.

This premise is in no way to be construed as minimizing the relevance of medicine but rather to point up the fact that there are some things even more important than health. We need to remind ourselves that the soul is more important than the body. A corrupt and unhealthy soul in a sound body is a menace to mankind, but an honest, god-fearing, consecrated soul even in a shattered and diseased body may light the world. One does not cleanse a polluted well nor purify the water by painting the pump.

This means, therefore, that a medical approach to the sick which ignores the "spiritual aspects" constitutes incomplete or inadequate therapy. The doctor of one hundred years ago was nowhere nearly so well equipped scientifically as his modern counterpart; yet he was able, through practicing the art of his profession, to cure many people who could not have been helped by all the medicines in the world. By his personal interest, his sympathetic understanding, and his consciousness of the importance of spiritual things, he imparted faith and made his patients feel better for having talked to him, even though the brightly colored pills he left behind him were only sugar.

Present day physicians adept in the art of medicine treat *both* the body and the soul, for that is what the art of medicine truly is; and it goes without saying that a healthy soul in a vigorous and healthy body is the best state in which a man may find himself.

With these thoughts in mind the role of religion in the treatment of the sick becomes obvious. It provides the *spiritual* approach; it enables us to minister to the patient's soul and to refresh and heal it. While this opportunity is particularly available to those of us who are physicians, unfortunately too many of us ignore it and, therefore, it is up to anyone who has the opportunity to fill in the gap. Its importance is tremendous, far more important than bodily healing. It is difficult to do and there are many failures. Never-the-less through religion we *can* bring to people, sick people particularly, something which we cannot bring them in any other way. Therefore it deserves our best and most constant effort.

Now the question at once presents itself: why is religion so important to all this? Could not a little common sense and sympathy do just as well if not better? Certainly there are many doctors adept in the art of medicine who aren't churchmen; what about them?

There are several obvious answers to these questions but I think the important one is this: in dealing with sick people religion offers us vital help in at least four different ways and we can get this help from no other source. There are probably other ways in which religion can help us in this work of healing souls, but the four I wish to discuss are, I believe, essential assets to those who would deal with sick people.

Instruments of God

The first of these is that only religion can give us the conviction that we are particular agents of God — that God is actually using each one of us to do His work. We are the right and left hands of God on this earth. When He wants to reach out and touch someone it is we whom He uses. So we must remember that unless we are helping, we are actually hindering. An automobile stalled in the middle of a busy street holds up traffic just about as much as if it were backing up. So we, unless we are working with and for God, are delaying the day when His kingdom on earth shall be an accomplished fact. Since, therefore, we are the channels of His love and the executors of His designs, it is necessary that we be convinced of His presence in us continually, if we are to further His work and not hinder it. Only religion, with its firm belief in a loving personal God as revealed in Christ, can give us that conviction.

The Role of Faith

Faith is the second thing religion teaches that is necessary to sick people and to us who deal with them. Sick people need faith in abundance: faith in their doctor, faith in themselves, faith in the future and faith in God.

A patient who feels his doctor is not doing everything he can for him is obviously under a severe handicap in getting well. Frequently this is because the physician doesn't explain things to the patient or, if he does, he may use such large and complicated words that no self-respecting layman could understand him.

On the other hand, strangely enough, this lack of faith is frequently the fault of the patient in that he does not tell the doctor what is really the matter. It may be that he is scared and is reluctant to tell the doctor anything lest his fears be confirmed. Unless the latter ferrets out his worry or has a flash of intuition, he cannot possibly help him. This can perhaps be best illustrated by a specific case.

> A very nervous and obviously terrified woman came for a consultation saying that there was nothing really wrong with her, she just wanted a check-up. After a thorough examination which revealed no pathology, she was told that nothing was wrong. She obviously was dissatisfied with the report, and none of her apprehension had disappeared. She was then told that another fact which the examination revealed was that she definitely did *not* have cancer. Her immediate emotional relief was very apparent and her anxiety ceased.

Fortunately that patient's problem was a simple one; never-the-less a similar attitude in a more complicated situation can completely baffle a doctor and cause the patient to go away feeling that the doctor is worthless and that they have no faith in him.

Here is an opportunity for the parish minister to help his sick parishioners by encouraging them to confide in their doctors. Medical training does not necessarily provide physicians with "psychic" power to read people's minds!

Some patients take great pride in their stoicism and thereby delay diagnosis or prolong treatment. Often the stoical "front" is assumed only for the physician. Frequently nurses in the hospital tell us that certain of our patients complain of considerable pain or of inability to sleep. When, however, we ask the patients themselves about these difficulties, they often deny or minimize them. Confidence creates confidence and if a sick person is to have faith in his doctor, his doctor must also have faith in him.

The second sort of faith a sick person needs is faith in himself. A discouraged, demoralized patient who does not sense the dignity of his own personality is not going to get well even if the doctor does cure his pneumonia. He needs to have the vision of this dignity restored before he can be really cured, for he must have faith in himself if he is to go on.

Faith in the future is necessary, too. To put it plainly, a sick person has to have something for which to get well. There has to be something worth fighting for whether it be home, friends, business, or just love of living. Let us again consider a clinical illustration.

A young, married woman had been admitted to the hospital with a diagnosis of arthritis. She was severely handicapped and had considerable pain. She soon began to manifest an intense hostility towards other patients on the ward. One day her physician asked her why she was so discouraged. Through a flood of tears she told her life story which included loss of both parents when she was 13, a long and bitter economic struggle which ceased with a successful marriage. A home and two children added to her happiness. Then unemployment, financial crises, and illness undermined everything. During this interview she was enabled to rediscover some of the values which justified getting well. A marked personality change for the better followed. The resources of medical social service were enlisted. There was also a marked improvement in the response of her illness to the treatment.

Faith in your doctor, yourself and your future are three very practical kinds of faith; and although faith in God covers all three of them and much more besides, it is, strangely enough, apparently not essential that a person have this fourth all-encompassing faith in order merely to regain physical health. Of course it is easier if you do have it, but it is not essential.

For those of us, however, who are dealing with sick people and trying to give them the faith they do need, it is the most important of all; without it our effectiveness is almost nil. The surprising impact which early Christianity had on people, even scientific and presumably skeptical ones like St. Luke, was due to the blazing faith of the apostles and early converts, those people who had actually seen or spoken to Jesus. It takes that kind of faith to induce faith in other people and only if we have it outselves, can we in fullest measure help them to better and richer lives.

Vis Medicatrix Dei

It is a very interesting thing to see what happens to sick people who suddenly develop faith. They frequently get better. Dr. Richard C. Cabot in *The Art of Ministering to the Sick*,[1] has a whole chapter on this phenomenon. He calls it "Vis Medicatrix Dei," the healing power of God. The case of the arthritic woman is an excellent example of this. She didn't start to improve until she developed faith.

God has made our bodies with a tremendous capacity for self healing. We throw off infections, we grow new skin, we get rid of foreign bodies, we restore upset chemical balance in a great many cases without any medical help at all. This power is the gift of God and most of the time a doctor's efforts are directed towards helping the patient cure himself. When we take sulfadiazine, the drug does not actually kill many bacteria; it stuns them and our body completes the job. When the physi-

[1] By Richard C. Cabot and Russell L. Dicks; Macmillan.

cian lances a boil, he is merely speeding up a process that the body would probably complete all by itself if given enough time. This healing power of God is prevented from working fully and effectively by worry or anger or fear and is released to do its work completely only by faith. That is why from a practical point of view alone faith is so important. No one who is upset or fearful or unhappy is utilizing to the full the healing power of God.

The Challenge of Religion

The third way in which religion can help us in our dealings with sick people is through the challenge it offers. We may not appreciate the importance of offering sick people a challenge, but it is sometimes the only way to health, particularly in those who have lost their faith in the future, or those whose illness has made them self-centered and selfish. Sickness frequently does both of these things and the challenge to forsake self and live for Christ, to lose our lives in Him and we may find them again is the only antidote to these ills of the spirit. The healing power of God cannot work in selfish people. Even before I went to medical school I saw a dramatic example of that fact.

> Two men were admitted to the Grenfell Mission Hospital in Labrador on the same day. Both had tuberculosis. The sicker of the two was happy, unselfish and cooperative; the other was morose, complaining and self centered. After two months of similar care, the first man (who had been sicker to start with) was discharged greatly improved. The other man was dead.

The second man had never heeded the challenge which the first patient had obviously accepted. Another case illustrates this point even more dramatically.

> A thirty-five year old married woman had been told that she had inoperable cancer. The inevitable separation from her husband and two children added to her despair and hopelessness. Her physician finally said to her: "You are a very charming person, you have been a good wife, an excellent mother, and an upstanding member of the community. In other words, you have done a pretty good job. But so have thousands of other people. Now here is your chance. You can live the rest of your life in such a way that your friends will all pity you. Or you can live it so that it will be an example and an inspiration to all who know you. Here is your chance to be somebody, to be different, to make your mark in the world. It's up to you."
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> The challenge was accepted although the burden of pain made it often very difficult. There were times of discouragement and despair but she always overcame them. Finally, when her condition no longer made it advisable for her to be cared for at home, she presented herself to the research department of a famous medical center and gave the doctors full permission to experiment.

Growth Through Adversity

The fourth help that religion offers us in dealing with the sick is supplementary to the challenge it offers and that is the example of the apostles in the few months following Christ's death. It is this example which gives us the power and the understanding to answer the challenge not only when we are sick, but in all our discouragements and troubles.

It is hard to imagine a more discouraged and disillusioned group than the close followers of Christ immediately after the crucifixion. All that they had worked for during their long and exciting years, all the promises of God's kingdom, all the dreams of a new world had disappeared completely with Christ's death. Their enemies were triumphant, and they even had to be careful about showing their faces around Jerusalem. But then, to this defeated and despairing group of men came the spirit of God, in the form of tongues of fire, and immediately they rose up and went forth to spread Christianity over the world. They made the cross the symbol of their faith. *Because* of the cross — not in spite of it — they endured hardship and death. The cross was their inspiration and the source of their power; and looking back across the centuries we can say that the crucifixion, which was so terrible for Christ's friends, was the best thing that ever happened in the world *because they made it so*, with God's help. It is the same way with our troubles and illness and sorrows: it is not the event that is good or bad, it is what we make of it; it is not what happens, but our reaction to it that counts.

It is a sad fact, though I am sure a true one, that we only grow spiritually when we are facing and overcoming trouble or sin. I might add that God seems to give us plenty of opportunity for such growth! This is particularly true in illness where our natural inclinations make us shrink spiritually. But just because of this the opportunity for such growth is there, both for ourselves and for the sick people to whom we talk, if we would only avail ourselves of it.

THE WASHINGTON CONFERENCE

REV. ROLLIN J. FAIRBANKS
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NEARLY two years ago Dr. Robert A. Clark, clinical director of the Western State Psychiatric Institute in Pittsburgh, suggested that it would be helpful to have a conference of clergy and psychiatrists who were concerned about mutual problems. Conversation and correspondence with other interested persons confirmed this suggestion, and last March such a conference was held at the College of Preachers in Washington. It was sponsored by the Institute of Pastoral Care in cooperation with the National Committee for Mental Hygiene, the Commission on Religion and Health of the Federal Council of Churches of Christ in America, the Council for Clinical Training, and the Massachusetts General Hospital.

Planning

A planning committee consisting of both psychiatrists and clergymen organized the details of the conference. It was agreed, for instance, to accept certain necessary restrictions in order to be able to concentrate upon the subjects for discussion. These restrictions provided first of all that attendance be limited to clergymen and psychiatrists although it was recognized that social workers, clinical psychologists, lay analysts, and even directors of religious education are equally concerned with the relationship of religion to psychiatry.

Although science is not denominational, it was recognized that some scientists are. We realized that our deliberations would not be concerned with pure science but rather a science as interpreted by minds which have been influenced by certain cultural heritages. In order to minimize differences, therefore, attendance was restricted first of all to Protestant clergy who had had some clinical training in understanding human nature or who were devoting a large portion of their time to the ministry to individuals.

Psychiatrists, likewise, were selected on a basis of their Protestant background and their genuine interest in (although not necessarily

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acceptance of) religion. In other words, while no orthodoxy was sought, it was acknowledged that a minimum of cultures would assure a minimum of digressions or distractions from the subjects to be discussed.

In order to provide for complete identification with the conference, it was arranged that each topic would be presented by *both* a clergyman and a psychiatrist. The speakers were urged to base their remarks on actual clinical observations rather than excursions in speculation. Because of all these provisions, there was a remarkable and unique concentration upon the program itself.

The Program

The first topic dealt with "Procedures of Cooperation Between Clergy and Psychiatrists." Similarities and differences were pointed out quite candidly and, I believe, fairly. So-called "therapeutic imperialism" was decried in both professions. The value of consultation rather than always seeking to transfer the individual from one profession to another was clearly indicated. The wisdom of employing multiple relationships in a program of therapy was stressed. The nature of bereavement was discussed thoroughly, since it constitutes one of the most obvious situations in which both professions can make contributions.

The next subject was "How the Clergyman and the Psychiatrist Can Aid Each Other in Counseling on Marital Situations." The increasing load of marital problems was acknowledged by both professions, as was the importance of pre-marital counseling by the pastor. Preparation for marriage, it was pointed out, begins not with late adolescence but during the individual's childhood when concepts of marriage and attitudes towards sex are being acquired. These early ideas frequently survive any superimposed indoctrination — even on the college level — and return to jeopardize marital adjustments. Once again it was recognized that both professions were dealing with a joint problem.

The third topic was greeted with considerable hopeful anticipation. Both professions were desirous of further enlightenment. The title was "The Respective Functions and Limits of the Clergyman and the Psychiatrist as Counselors." If these areas could be marked off and clearly labelled, then the matter of trespassing would be settled once and for all. Ironically and inevitably no such Solomonic decision was reached. We were reminded of the futility of leading horses to water when there is an unwillingness or determination not to drink! In other words, the patient or parishioner often has preferences or prejudices as to whether he desires psychotherapy or spiritual guidance.

Another determining factor which was brought out is the matter of a previously established rapport. If the individual already has a good relationship with a psychiatrist or a clergyman, or has a positive feeling toward either of the two professions, that fact in itself will determine to a large degree who can best serve as therapist. Should the

personal difficulty be of the nature of a *severe* disorder, however, it should of course be referred to a psychiatrist. On the other hand it was also acknowledged that many clergy serve in isolated areas where actually no psychiatric assistance is available and must, therefore, be prepared to administer such "first aid" as is humanly possible.

On the morning of the second day we gathered in the small chapel for a brief meditation service which was conducted with rare sensitivity for and understanding of human nature. Our leader was the Bishop of Washington who pointed out that man's needs are seemingly paradoxical. He wants to reveal and yet to conceal. He seeks to bare his soul to God and also to escape the scrutiny of God. Man has a deep need to belong, and a yearning to be reconciled with himself, his fellow man, and with God. Those of us who attended came away from the chapel deeply moved that so much sound understanding of the very purpose of the conference could be incorporated so fittingly into a devotional service.

The fourth topic was perhaps the most provocative in the entire series. It dealt with "The Relation of the Counselor's Philosophy of Life to His Therapeutic Results." In other words, does it make any difference what we believe, when we seek to provide professional therapy?

I wish that I might report some profound conclusions. Actually all that we were able to do was to "scratch the surface," so-to-speak. Both professions acknowledged that greater consideration must be given to the place of values in a therapeutic relationship. At the same time it was pointed out that it is sometimes difficult to ascertain what an individual's *actual* values are! Until relatively recently psychiatry has been primarily concerned with a descriptive approach. Clinical experience today, however, has made it obvious that values can no longer be ignored in both understanding and in treating the patient. The clergy, on the other hand, have become increasingly aware of a wide variance at times between those values which have been accepted intellectually and those which are actually motivating behaviour.

The fifth subject was "Methods of Cooperation on the Educational and Preventive Aspects of Mental Health." It became obvious from both the presentations and the discussion that the two professions need to *share* more, as well as cooperate, if a sound educational and preventive program is to be realized. As one psychiatrist pointed out, both the clergy and the psychiatrists should take as their goal the development of as many emotionally mature and intellectually informed adults as the limitations of human nature and the scarcity of trained leaders permit.

The last subject was "Joint Research: Desirable or Possible?" One of the difficulties in comparing the experiences of the two professions is the scarcity of tangible, clinical evidence in the pastoral field. The experimental approach is still rare in theological study while, on the other hand, it is essential to psychological study. Joint research *is* desirable and needed; mutually acceptable methods, however, have yet to be fully developed.

Evaluation

Even from a perspective of nearly a year it is still difficult for those of us who attended the conference to be completely objective in any evaluation which we might attempt. The gathering was so significant and it was characterized by such a splendid spirit, that we cannot yet wholly remove ourselves from it. Despite this limitation, however, certain things continue to stand out.

First of all, there was throughout all the deliberations a constant note of sincerity. Professional egotism was at a minimum. There was a genuine desire for the truth, wherever it might be found, which was stronger than a natural defensiveness. At first some restraint was apparent and inevitable as forty strangers gathered at an unfamiliar place to attempt something which had not been done before. Soon, however, this was dissolved by a contagious enthusiasm and an eagerness with which we all moved from topic to topic.

Both groups wrestled with the problem of denominationalism. For some of the clergy, for instance, the sacramental approach was more meaningful than for others. Among the psychiatrists there were psychoanalysts and those without that training and experience. There were disciples of Freud and followers of Jung. "Static" and "dynamic" schools of psychology were represented. Despite these differences, however, there was complete agreement as to the focus of the conference.

In retrospect it would appear that theology failed to contribute as much as it might. Those of us who represented religion demonstrated an understanding of psychiatry but perhaps we offered too little of our own unique resources. We emerged from the conference more in the role of allies rather than contributors. The psychiatrists, on the other hand, shared generously of their insights but at the same time revealed only a vague and somewhat theoretical understanding of just what the minister does.

The net result of all this has been a conviction on the part of both professions that we must "go on" from here. We have started something which demands continuation. The direction of further deliberations would seem to me now to point *beneath* specific areas of cooperation and to lead us to explore jointly basic concepts. This probably could not have been done at the first conference because we had not yet achieved a mutual respect rooted in a joint project. Now that this is ours, however, we can dispense with the introductory formalities and courtesies and plunge into the deeper waters wherein life takes on a new dimension.

For the participating psychiatrists this will perhaps mean inviting some criticism and misinterpretation, particularly from within their own ranks, for actually it will involve "walking on water," so-to-speak, in the sense that many tangibles will of necessity be left on shore. For the clergy, on the other hand, it will mean admitting into the "holy of holies," into a hitherto private preserve, a group of men and women who are to all

practical purposes and training "from Missouri." Needless to say given these conditions something is bound to happen. Either new light will appear or confusion and possibly disillusionment will follow.

What are some of these basic questions which deserve and *need* joint consideration? First of all, there is the concept or nature of man. Is he victim of a deterministic process whereby early experiences predetermine all his later decisions? Or, does he actually possess a free will? Have we conclusive clinical evidence to support either premise?

Are values but rationalizations of our desires? Or are they external realities which we inherit or otherwise acquire? Are there absolute values? What is the relationship between behaviour and values?

Moving back towards shallow water there are two relevant subjects which also deserve further consideration. The first is the matter of the relationships of the psychiatrist and of the minister to people in trouble. Are they the same? Or is there something unique about a therapeutic relationship? Is there also something quite different about a pastoral relationship? Perhaps they are not as similar as we have assumed. If not, then this should have significance when we move on to the second subject and consider methods.

Textbooks on psychiatry continue to be vague as to the actual content, the specific techniques used, in psychotherapy. Psychiatrists themselves are not excessively garrulous on this subject. Likewise the few textbooks on the pastoral relationship are equally vague. Aside from the use of sacraments, scripture and prayer, are all the other tools such as suggestion, persuasion, education, interpretation, etc., identical for both professions?

Epilogue

Looking back upon what was attempted, and reviewing what still needs to be done, I am wondering whether possibly we are naively walking "where angels fear to tread." It may well be that we are dealing with highly controversial material. Certainly isolation is not the answer and neither is orthodoxy.

May I take the liberty of closing my report with a deeply sincere and prayerful (if you will) observation. As a Christian citizen, not only of this country but of the whole world into which we are now so inextricably woven, it is my profound hope and desire that the insights of psychiatry into human nature can be combined with the aspirations and values of religion so that we *can* achieve a better life (in a non-material sense) "on earth as it is in heaven." We who are privileged to be parents — and many others to whom that privilege has been denied — yearn to bequeath to our children a better world than that into which *we* were born.

Note: For further information regarding this Conference see page 43.

The JOURNAL *of* PASTORAL CARE

VOL. 1 WINTER, 1947 NO. 2

EDITORIALS

Our Editorial Board Expands

With this issue we welcome to our Editorial Board three additional members.

Professor Guiles was one of the first students of clinical training at the now-historical Worcester State Hospital. For many years he has given generously of both time and funds to the practical training of ministers, particularly at the Andover Newton Theological School where he is a member of the faculty.

Chaplain Dicks is another pioneer in clinical pastoral training and perhaps the most prolific writer and teacher in the field. For three years he has ably served as Pastoral Work Editor of *The Pastor* which is the only publication to date that prints detailed pastoral interviews. He is chaplain of the Wesley Memorial Hospital in Chicago.

Chaplain Ballinger is director of clinical pastoral training at the University Hospital, Ann Arbor, Michigan, where he is carrying out a remarkable program of coordination between the resources of medicine and religion. His background of both parish and military experience has given him an exceptional understanding of pastoral problems.

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Future Issues

Since the publication of our first issue certain policies have crystallized which we wish to share with our readers. The Journal will be published in correlation with the four seasons of the year. Circulation will be on a membership basis (see page 5) rather than subscription. We shall strive to offer a maximum of *clinical* material, and reprint only articles that are particularly relevant and unlikely otherwise to reach our membership. Our emphasis will continue to be on the pastoral ministry, with particular reference to those ministering in parishes. In order to avoid a preoccupation with methods and techniques, however, we shall also seek to offer from time to time basic studies in the theological implications of pastoral care.

Some of the articles planned for future issues will deal with the pastoral significance of infant baptism, pastoral counseling on the university level, establishing a pastoral counseling center, the unique contribution of religion to mental health, ministering to the dying and to the bereaved, and theological implications of clinical training.

Psychiatrists Regard Religion

The Group for the Advancement of Psychiatry consists of a number of members of the American Psychiatric Association who are united "in an effort to accelerate psychiatric progress by mutual study and discussion of outstanding problems, clarification of concepts, the determination of psychiatric needs and concrete steps needed to meet these needs."[1] At their second meeting held last summer the following statement was prepared.

> For centuries, religion and medicine have been closely related. Psychiatry as a branch of medicine has been so closely related to religion that at times the two were almost inseparable. As science developed, however, medicine and religion assumed distinctive roles in society, but they continue to share the common aim of human betterment. This also holds true for that method of psychiatry known as psychoanalysis.
>
> We, as members of the Group for the Advancement of Psychiatry, believe in the dignity and the integrity of the individual. We believe that a major goal of treatment is the progressive attainment of social responsibility. We recognize, as of crucial significance, the influence of the home upon the individual and the importance of ethical training in the home. We also recognize the important role religion can play in bringing about an improved emotional and moral state.
>
> The methods of psychiatry aim to help patients achieve health in their emotional lives so that they may live in harmony with

[1] *Mental Hygiene*, Vol. 31, p. 682, October, 1947.

society and with its standards. We believe that there is no conflict between psychiatry and religion. In the practice of his profession the competent psychiatrist will, therefore, always be guided by this belief.

The clergy do well to welcome the formation of this Group, its work, and particularly the foregoing statement for the latter's intent is stronger than may be apparent at first reading. When we recall that the Group is made up by members of several faith groups, and by a number without religious concern for themselves, we may consider it as representing an advance.

Analysis of the statement, however, suggests that the psychiatrists are inclined to equate religion with morals, and morals with not much more than the conformities of convention. For this misinterpretation of both the Jewish and Christian traditions the clergy and churches are undoubtedly to blame. No leading Christian or Jewish theologian today espouses a moralistic approach, but it is rife through the churches just the same.

Of course we are interested in ethics — but the freedom of the Christian man is a far cry from comformity to social convention. Like it or not, we have not yet succeeded in demonstrating to the psychiatric group that Christian ethics and moralism are two different things. If our congregations understand it, the psychiatrists will too.

Notable by its absence from the statement is any reference to the point which psychiatrists have done much to illuminate, that a man's religion may be warped if the man is warped. As some one has put it, "A man's religion is probably not better than he is." While some of us think that one has to add "Sometimes a man's religion *is* better than he is," we have found the point of great value. Perhaps the psychiatrists merely exercised restraint in not pointing out their particular contribution. On the other hand, it may be they have not yet faced the implication of their own point, which might be stated thus. If religion is warped because personality is twisted, then the observation of however many twistings of religion is no negative commentary upon religion itself.

So we sincerely welcome the statement by the psychiatrists. But in honesty we tell ourselves that, if the psychiatrists are to make a stronger and more adequate statement, it must be preceded by more work on our part in demonstrating what religion in the Jewish-Christian tradition really means, and that none of us wants to defend unhealthy interpretations of religion any more than would the psychiatrists themselves.

A New Journal

The assurance of professional literature in the field of clinical pastoral training has been strengthened with the publication of a new journal by the Council for Clinical Training, Inc., under the able editorial direction of Chaplain Robert D. Morris of the Episcopal Hospital in Philadelphia.

It is called *The Journal of Clinical Pastoral Work* and will be issued four times a year, one issue to serve as a catalogue for the Council's training program. It is being published "in the interests of the pastoral ministry in parish and institution," and the articles in the first issue confirm this policy. The subscription price is $2.00 and inquiries should be directed to the Council at 2 East 103rd Street, New York 29.

In order that our readers may become acquainted with this new publication, the Council has agreed to mail the Spring issue to all those on our membership list. The Institute, in return, will likewise send *The Journal of Pastoral Care* to those who have subscribed to the Council's new Journal.

The Lahti Conference

From the *Amerikan Suometar*, a Finnish newspaper published in Michigan, we have learned of a significant conference of doctors and pastors which was held in Lahti, Finland. There were more than 200 present, including representatives from Denmark and Sweden. No official report of their deliberations is available but the following comment by Bishop Max Bonsdorff is shared:

> "Many of the existing difficulties call for cooperation between doctors and ministers. Someone has said that Christianity today is an ambulance-service wherein both doctors and pastors are needed. Inasmuch as the whole world is like unto a battlefield, this type of service, in which pastors and doctors vigorously strive together to aid mankind, is also tremendously important."

Our Contributors

In response to readers' request we propose in each issue to share editorially a few facts about our contributors. Ina May Greer ("Token Relationships") is a research worker in the field of psychiatry and has collaborated both in this country and abroad with psychologists and psychiatrists in the writing of books, speeches, and papers. For the past three years she has been a valuable member of the teaching staff of the Institute's Summer School. Miss Greer has an exceptional and an appreciative understanding of religion and the pastoral relationship.

Russell L. Dicks ("Spiritual Crises in Illness") hardly needs any introduction since he has written more books in the pastoral field than any other one writer. With Dr. Richard C. Cabot he laid the foundations for pastoral work at the Massachusetts General Hospital, which later were to grow into the present Institute of Pastoral Care of which he is an Honorary Member.

David E. Roberts ("Theological and Psychiatric Interpretations of Human Nature") has long been interested in clinical training and psychiatry and their implications for his own field of theology. In his

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teaching, writing, and lecturing he has repeatedly raised significant questions, particularly regarding the nature of man as viewed by dynamic psychiatry and modern theology.

James H. Burns ("Emergency Baptism") is not only Associate Editor of the *Journal* and Associate Director of the Institute of Pastoral Care, but also carries the heavy responsibilities of a full-time teaching chaplaincy at the Massachusetts General Hospital. He has developed a unique ministry to student nurses through the organization of a Guild for Protestant Nurses.

G. Douglas Krumbhaar is a practicing physician in Boston, a member of the obstetrical service of the Massachusetts General Hospital and a regular lecturer in the Summer School of the Institute of Pastoral Care. His interest in people and religion has always extended far beyond his professional relationships.

Rollin J. Fairbanks ("The Washington Conference") devotes most of his time to the administration of the Institute of Pastoral Care and teaching at Harvard Divinity School and the Episcopal Theological School in Cambridge. He recently was elected to membership in the National Committee for Mental Hygiene.

Now to identify those who have reviewed books for this issue we come first to Seward Hiltner who is the Executive Secretary of the Department of Pastoral Services of the Federal council of Churches of Christ in America. Malcolm B. Ballinger is Chaplain at the University Hospital of Ann Arbor, Michigan, and Director of Clinical Pastoral Training. Henry H. Wiesbauer is Director of the Pastoral Counseling Center and an Associate Director of the Institute of Pastoral Care. C. Charles Bachmann is a former Navy Chaplain who is now doing graduate work at Boston University. William Savin is the new Executive Director of the Massachusetts Society for Mental Hygiene.

BOOK REVIEWS

Physicians of the Soul: Charles F. Kemp; Macmillan, 1947. 314 pp. $2.75.

The author of this volume has contributed important service to all those interested in improved pastoral care. For in presenting a simple and readable history of pastoral counseling, with emphasis on the past forty years, he has brought together a number of facts which have not previously been considered in their relationship to the development of pastoral counseling.

The treatment of the period up to the present century is brief, only seventy pages; and while not original for the most part, it is a useful summary. A second section deals with developments to the first world war, and a third, with the influence of contemporary movements like missions, the social gospel, and faith healing. The last section discusses

the developments in social case work and medicine, in clinical pastoral training and theological education, and other more recent trends.

The author has chosen to present his material on a purely descriptive level, that is, without an attempt to evaluate the relative significance of different men and points of view and movements. In some respects this makes the volume of less interest than it would otherwise be, but it probably widens the number of pastors who can thereby profit from it. It can not be called a definitive history if history be the evaluation as well as the description of developments in the past. But it suggests the wealth of material that will await future historians of this field.

The author has performed a prodigious feat in becoming acquainted with all the writings mentioned in his volume. For as pastor of the First Christian Church, Red Oak, Iowa, he not only cared for a parish while writing this, but in the absence of a nearby large library he had to secure many volumes on loan from various places across the country. His thoroughness in taking such pains has made his book more comprehensive than it would otherwise be. We may expect other significant writings from Charles Kemp.

SEWARD HILTNER

•

Techniques of Counseling in Christian Service: Charles Reed Zahniser; Gibson Press, 1946. 29 pp. 50c.

This "handbook for pastors and other Christian workers" endeavors to set forth the essential *techniques* rather than the occasion, nature, and philosophy of Christian service. It is a highly condensed presentation of material which originally was used in lectures and case conferences among pastors and others pursuing graduate vocational courses in Christian service.

After defining clinical counseling as being soundly scientific in approach and largely religious in its dynamism, Dr. Zahniser describes the levels from which persons come for counsel, discusses the problem of finding time for counseling, emphasizes the importance of the proper setting for the interviews, describes some of the factors which help secure rapport, enumerates three mortal sins of a counselor, pleads for the treatment to consist largely of allowing the enquirer to talk the situation out and make his own decisions, and outlines how the counselor may introduce religion into the process by having an understanding and due appreciation of each counselee's own religious background.

Although Dr. Zahniser does not make any new contribution to the techniques of counseling, he does present in convenient handbook form most of these techniques which are generally accepted today as being the most effective, and he has rightly emphasized the need for introducing the function of religion itself as a dynamic factor in psychiatric therapy. One wonders why such a brief presentation has been produced in a bound edition rather than in a cheaper pamphlet form.

MALCOLM B. BALLINGER

All of Us Have Troubles: Harold Seashore; Association Press, 1947. 50 pp. 25c.

Lee Steiner's *Where Do People Take Their Troubles?* came as a revelation to the whole community. She proved how great is the number of people who pay good money and invest valuable time with "counselors" and "therapists" who proffer strange nostrums with varied results. In his *Families in Trouble*, Dr. Earl L. Koos maintains that most people in trouble today do not know where to turn for professional and effective assistance. To these two studies many of us can add our own hearty endorsements, based on findings we experience in our professional practice.

All Of Us Have Troubles is a timely booklet, and Mr. Seashore has rendered the community a real service in both exposing "quacks," as well as in describing what he well terms "legitimate doctors of the mind." The booklet contains specific advice on how to recognize a genuine psychiatrist, a psychoanalyst, a professional clinical psychologist, and by giving counsel concerning guidance tests and those who administer them.

The presentation is popular in style, and has a number of humorous cartoons. It should find a real place in the parish library, and especially in the tract rack or literature table of the parish church.

HENRY H. WIESBAUER

•

When You Marry: Duvall and Hill; D. C. Heath, Boston, 1945. 450 pp. $2.40.

This book will prove a rich resource for parish ministers. First of all, it is an authoritative reference for those doing marriage counseling; it also provides an excellent guide for those embarking upon marriage; and it constitutes one of the best textbooks for such subjects as adolescence, marriage, and parenthood. Each chapter begins with questions which provide the focus of the material that follows. Clever and amusing cartoons augment the fluid, delightful style of the authors. The check tests which are found in almost every chapter should be used with reservations, and rigid interpretations are to be avoided. The approach of the authors is comprehensive, realistic and balanced. Marriage is rightly viewed in terms of society. The order of presentation is logical and functional, as the following division headings indicate: Anticipating Marriage; What It Means To Be Married; The Making of a Family; Family Life Yesterday, Today and Tomorrow. Appendices A and B give a Marriage Prediction Scale and a list of reliable marriage and family counseling services.

C. CHARLES BACHMANN

•

Personality of the Preschool Child: Werner Wolff; Grune & Stratton, N. Y., 1946. 341 pp. $5.00.

Many of Dr. Wolff's observations concerning the verbal, graphic, and dramatic expressions of children will be of value only to the highly

trained specialist. The two central themes that the child has as his task the search for his self and that he lives in a world isolated from that of the adult often appear oversimplified; and the interpretations of the recorded behavior occasionally seem to draw a long imaginary arc; the book, nevertheless, contains a wealth of information about the way children think, feel, and act. The first and last chapters will be of particular interest to parents, ministers, and other educators, pointing out as they do the differences between the child and the adult and how these can and should shape the educative approach.

The child, for example, is regarded as having fewer associations, thought patterns, and motivations for action, as being unable to select the common denominator and to generalize, and as relating his thought and mood to emotions rather than to plans, conclusions, and knowledge. He possesses a more dynamic memory, effective only for material which interests him, and needs order and repetition if he is to succeed in his attempt to develop recognition and discrimination. He is insecure because of the discrepancy between what he feels inside and finds outside and at the same time tries desperately to establish rules and explore reasons by incessant questioning, only to find that the adult can not give him satisfactory answers. His aggression, as well as his early signs of joy, are at first blind explosions of undirected energy. His social relationships grow through the stages of monologous action, discharge of aggression, identification, the erection of ideals, search for possession, competition, directed love and hate, reciprocal giving, altruism, and finally cooperation.

Dr. Wolff defines personality as "an integration of patterns," not to be "classified according to rigid standards but only judged according to dynamic directions," the integration and developmental drift of the trends or functions operative at any given moment being the guiding principal of the whole, stimulating or retarding certain reactions and expressions and determining the selection of experiences which will modify development. The goal of education is visualized as helping the individual "become sure of his ego, balanced in his self, and, finally, independent of the bondage of his individuality."

INA MAY GREER

•

The Philosophy of Insanity: (author anonymous); Greenberg, N. Y. 116 pp.[1]

Dr. Frieda Fromm-Reichmann says in her introduction to this surprising little volume which she has resurrected from oblivion: "Nobody of whom I know among scientific and non-scientific authors has expressed the idea of the essential human likeness between mentally disturbed and emotionally stable people more convincingly and in more beautiful language than did this remarkable recovered psychotic in the middle of the nineteenth century."

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[1] First published in Glasgow in 1860.

It matters not that the author's conjectures concerning the evils of tobacco, and the role which the stomach plays in mental health are guesses of a century ago. Nor does it matter that he only roughly approximates the neurological classification of the functions of the cerebrum and cerebellum. He is wiser than most of us today in his understanding of man's inhumanity to man.

Many of his paragraphs have a stateliness and a cadence as stirring as is his perception of the truth. Speaking of religious fanatics he says: "Man can patiently submit to be contradicted, can reason calmly and rationally upon almost any subject except religion. Contradict or question the truth of the most absurd dogma connected therewith, and instantly the spirit of intolerance leaps into life and the fanatical believer would condemn all who differ from him to death here and perdition hereafter. . . . As a flood of fire from the bosom of a living volcano sweeps down the verdant slope, turning flower and fruit into smoke and ashes, so does fanaticism sweep over mercy and truth, and where these glorious attributes might have flourished we find cruelty, intolerance, injustice, tyranny in its most malignant form, and a heart as insensible to human suffering as the cooled down lava is to the desolation around."

Another significant fact is revealed by this book. Although one hundred years ago almost none of the present day therapies were available, the reader is constantly impressed by the kindliness of the care which the author describes as accorded to the sick people at Gartnavel. Just when Dorothea Dix was crusading in this country for an attitude of simple humaneness and sympathy toward the "lunies," in Scotland the atrocities which characterized "old Bedlam" had already been replaced by compassion equalling that of our better hospitals of today.

An evening spent with this author must certainly convince the reader of two things: that society as a whole is scarcely less ignorant or superstitious regarding mental illness today than it was a century ago; and that the mentally ill comprise a segment of the human race whose economic, artistic, and cultural value is worth salvaging at any cost.

WILLIAM H. SAVIN

•

My Dear Ego: Fritz Kunkel, M.D.; Pilgrim Press, 1947. 147 pp. $2.50.

We all look forward to the day when psychiatrists and clergymen get together and combine their skills in helping people live abundant lives. Dr. Fritz Kunkel is to be commended for his contribution to the realization of this goal as he serves as consultant psychiatrist in connection with the First Congregational Church in Los Angeles. Few of us can hope to have such a consultant on our staffs, yet all of us can benefit from such a book as *My Dear Ego*, which can serve as a sort of assistant pastor. It is written for young people to help them see themselves as they really are and help them apply the tools of psychology to improve their character and their relationships with fellow men.

The book is divided into three parts. Part One: "I and We", expounds n simple language Dr. Kunkel's weighty concept of "We-Psychology" vhich has been described more fully in earlier books. Here it is described or teen-agers, showing the four basic types of egocentricity (Star, Bully, Clinging Vine, Turtle) and explaining how they can be resolved into more ealthful We-Experiences. Part Two: "Boy and Girl", is an excellent andling of the problems and hazards of love, sex, preparing for marriage; The Ten Years' Course" and "The First Five Years" programs are specially rich outlines of normal and healthful maturation. Part Three: Individual, Group and God", explains the difficulties of gaining inde- endence from parents and of developing a healthful attitude toward ellow men and God.

There are diagrams by Dr. Kunkel, as usual, and whimsical illustra- ions by Janet Smalley, which help clarify some of the concepts of "We- Psychology." He who has read previous books by Dr. Kunkel will recognize and better understand his peculiar but descriptive terminology; he who has not yet read his previous books will get an elementary intro- duction to his attempt to unify the findings of Freud, Adler, Jung, and Christianity.

The book is recommended to all pastors who have difficulty under- standing why young people sometimes act the way they do (and that ncludes just about all of us). The pastor can use the book as a guide for discussions with groups of young people, or he can put the book in the nands of young people themselves for private use and benefit.

MALCOLM B. BALLINGER

•

The Psycho-Analytical Approach to Juvenile Delinquency: Kate Friedlander, M.D.; nternational Universities Press, 1947. 296 pp. $5.50.

Since nearly all pastors are interested in juvenile delinquency because hey are often called in to help on such problems, it is desirable that every pastor know as much as he can about the subject. Unfortunately, here are about as many theories as there are experts in the field, all claiming to have the last word and explanation of the cause and cure. *The Psycho-Analytical Approach to Juvenile Delinquency* is written by he honorary psychiatrist, Institute for the Scientific Treatment of Delinquency (Britain) and Clinical Director of West Sussex Child Guidance Service, and proposes "to show which problems in the vast ield of research in delinquency can be solved by psychoanalysis; and n what way sociological and criminological research workers can make use of psycho-analytical findings in order to further their own investiga- ions." (p. vii). She further states that "the cooperation of sociology, criminology, penology and psychology (including psychiatry)" is needed f valuable results are to be achieved.

The book contains theory, case studies, and treatment. Part One: "The Development Toward Social Adaptation", portrays the strictly

Freudian concept of the lengthy process of maturation: "The sexual instinct passes through the oral, anal-sadistic and phallic phases before it reaches in puberty what we call the genital stage." (p. 22) The child's ability or inability to adapt himself to society depends upon satisfactory or unsatisfactory adaptation within the family group. Part Two: "The Failure of Social Adaptation", deals with delinquent behavior as those cases where the offender's attitude toward society is such that it will eventually lead to a violation of the law, and classifies these disturbances into three groups of causes: (1) due to an antisocial character development (into this group fall the majority of juvenile offenders), (2) due to organic disturbances (the Ego is put out of action by toxic or organic disturbances or a malfunctioning of the nervous centres), and (3) due to psychotic ego-disturbance (the Ego is unable to control instinctive urges on account of its inability to distinguish between reality and phantasy). Part Three: "Treatment", discusses the attitude of the public, the problems of diagnosis, psychological and environmental methods of treatment, the training of field workers, and the problem of prevention. The author reaches the conclusion that "psycho-analysis furnishes a scientific theory of the working of the human mind, in health and illness, and should therefore play an essential part in every branch of delinquency research. Sociological research . . . will bear fruit only if from the outset of any given investigation psychological factors are taken into account." (p. 286)

At the close of each section of the book is a bibliography which is obviously largely from the Freudian school, and largely European, although there are some references to such American authorities as Healy and Bronner of Boston.

It seems to the reviewer that nothing essentially new is brought forth in the book. It gives a good review of the psycho-analytic approach — unfortunately, both good and bad features of the Freudian concept. If one is to have a wholesome and adequate understanding of the problem one needs to supplement this approach with others. The reader needs to be warned that much more research with many more cases is needed to verify or reject this and other theories on the problem of juvenile delinquency.

MALCOLM B. BALLINGER

NOTES AND COMMENTS

An Institute on Religion and Psychiatry was held October 27–28 in Boston under the auspices of the Temple Israel Brotherhood. It was open to clergymen, other religious workers, psychiatrists, and social workers. Representatives of the three major faiths participated.

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Prof. Albert C. Outler of the Yale Divinity School has made a helpful contribution to the field of pastoral counseling by his pamphlet entitled *A Christian Context for Counseling*. It can be secured from either The Edward W. Hazen Foundation, 400 Prospect St., New Haven 11, Conn., or from the Department of Pastoral Services, Federal Council of Churches, 297 Fourth Ave., New York 10.

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A summary report of the papers presented at the Conference of Clergy and Psychiatrists held in Washington last spring is now available to members of the Institute. The supply is limited and distribution will be restricted to one copy per member.

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"Alcoholics Anonymous" has published an excellent booklet entitled *A.A.* It is written simply and illustrated with human interest stories. A copy may be secured by writing to the Alcoholic Foundation, Inc., P. O. Box 459 (Grand Central Annex) New York 17.

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Hope for Tired Minds is a moving autobiographical story of a business man who recovered from a serious illness. It was published originally by *Hygeia* and now can be secured from the author, Mr. Frank W. Kimball, 227 Walnut St., Dedham, Mass. The price is fifteen cents.

An alumnus of the Institute of Pastoral Care, Rev. Merrell D. Booker, is now chaplain of the Freedman's Hospital, Howard University, Washington, D. C.

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A shortened form of the service of Holy Communion (as it appears in the Book of Common Prayer) suitable for use with sick and shut-ins is available through the Institute.

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The National Committee for Mental Hygiene (1790 Broadway, New York 19) publishes a quarterly which every church should make available to its Sunday School teachers and parents. It is called *Understanding the Child* and the subscription price is one dollar. The National Committee also offers in pamphlet and reprint form other material of real value to the parish minister. Send for their order list.

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The Rev. Williams R. Andrews, formerly chaplain of the Elgin State Hospital, Elgin, Ill., and supervisor of clinical training at that institution, is now Protestant Chaplain at the Concord State Hospital, Concord, N. H. This new chaplaincy was created by the joint efforts of the hospital superintendent and the New Hampshire Council of Churches.

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A report on the opportunities for graduate study in the Boston area in the fields of religious counseling and human relations is now available from the Institute upon request.

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We also still have a few copies of Mrs. Grace D. Raynes' article on "Home Training of Mentally Deficient Children" which will be sent without charge.

The Massachusetts Society for Mental Hygiene (3 Joy St., Boston 8) offers two interesting folders: "Leading a Full Life After Middle Age" and "How to Get Along With Older People." There is no charge for these. The Society also publishes a helpful pamphlet entitled "Getting Along With Yourself and Others." The price is ten cents.

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Parish ministers will do well to become acquainted with *Marriage and Family Living*, a significant journal published by the National Council on Family Relations, 1126 East 59th St., Chicago 37.

A new full-time teaching chaplaincy has been created to cover two psychiatric hospitals in the Boston area. Inquiries and applications should be directed to the Committee on Institutional Ministry, Massachusetts Council of Churches, 14 Beacon St., Boston 8. The appointment will begin July 1, 1948.

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A limited number of course assistants will be needed for the Institute's 1948 Summer School, both in Boston and in Ann Arbor. Applicants must be ordained and shall have had clinical training. Honoraria vary from $100 to $150.

OUR HISTORY

Every organization has its antecedents. The roots of the Institute of Pastoral Care go back more than a score of years to an address given by Dr. Richard C. Cabot, entitled "A Plea for a Clinical Year for Theological Students." From this significant beginning has emerged the clinical training program which serves to train and develop personal and pastoral insights of hundreds of clergymen, both in this country and in Canada.

The first training course was established in 1925 at the Worcester State Hospital where Rev. Anton E. Boisen and later, Rev. Carroll A. Wise, chaplains, did much to provide a vital clinical experience for theological students. Dr. Cabot, however, believed that a more satisfactory experience could be secured in the general hospital and therefore in 1933 sponsored a program at the Massachusetts General Hospital under the supervision of Rev. Russell L. Dicks. Out of this experience came that pioneer work in the field of pastoral care, "The Art of Ministering to the Sick," by Cabot and Dicks. (Macmillan Co., New York.)

With the help of the Earhart Foundation and the leadership of Rev. A. Philip Guiles, the clinical training movement in New England gained considerable impetus. A Theological Schools Committee on Clinical Training was formed to correlate the program. In January 1944 this group was utilized as a frame-work around which the present Institute of Pastoral Care has been built.

OUR PURPOSE

Article II of our Constitution sums up succinctly the goal which the Institute has set for itself. It states that "The purpose of the Institute shall be to organize, develop and support a comprehensive educational and research program in the field of pastoral care, with special reference to the sick, using the opportunities offered by clinical training as a primary means to this end."

Part of this objective has been attained in the establishment of our Summer School. Occasional winter seminars have also been sponsored. The advent of this experimental journal constitutes another definite step. There remains the field of research which the Institute hopes to enter as soon as funds are available and projects are proposed and approved. In the meanwhile, however, clinical pastoral material is being created, recorded, evaluated, and filed for future study and research.

1948
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Session I — June 7–July 16

Session II — July 19–August 27

UNIVERSITY HOSPITAL — **Ann Arbor, Mich.**

Session IIA — July 19–August 27

Descriptive folder and application blank
may be obtained from

Rev. James H. Burns, *Associate Director*
Institute of Pastoral Care
Massachusetts General Hospital
Boston 14, Massachusetts

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